

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

CHAPTER 1460. STANDARDS REQUIRED REGARDING CERTAIN PHYSICIAN
RANKINGS BY HEALTH BENEFIT PLANS

Sec. 1460.001. DEFINITIONS. In this chapter:

(1) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(2) "Physician" means an individual licensed to practice medicine in this state or another state of the United States.

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

Sec. 1460.002. EXEMPTION. This chapter does not apply to:

(1) a Medicaid managed care program operated under Chapter 533, Government Code;

(2) a Medicaid program operated under Chapter 32, Human Resources Code;

(3) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(4) a Medicare supplement benefit plan, as defined by Chapter 1652.

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

Sec. 1460.003. PHYSICIAN RANKING REQUIREMENTS. (a)

A health benefit plan issuer, including a subsidiary or affiliate, may not rank physicians, classify physicians into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians, unless:

(1) the standards used by the health benefit plan issuer conform to nationally recognized standards and guidelines as required by rules adopted under Section [1460.005](#);

(2) the standards and measurements to be used by the health benefit plan issuer are disclosed to each affected physician before any evaluation period used by the health benefit plan issuer; and

(3) each affected physician is afforded, before any publication or other public dissemination, an opportunity to dispute the ranking or classification through a process that, at a minimum, includes due process protections that conform to the following protections:

(A) the health benefit plan issuer provides at least 45 days' written notice to the physician of the proposed rating, ranking, tiering, or comparison, including the methodologies, data, and all other information utilized by the health benefit plan issuer in its rating, tiering, ranking, or comparison decision;

(B) in addition to any written fair reconsideration process, the health benefit plan issuer, upon a request for review that is made within 30 days of receiving the notice under Paragraph (A), provides a fair reconsideration proceeding, at the physician's option:

(i) by teleconference, at an agreed upon time; or

(ii) in person, at an agreed upon time or between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday;

(C) the physician has the right to provide information at a requested fair reconsideration proceeding for determination by a decision-maker, have a representative

participate in the fair reconsideration proceeding, and submit a written statement at the conclusion of the fair reconsideration proceeding; and

(D) the health benefit plan issuer provides a written communication of the outcome of a fair reconsideration proceeding prior to any publication or dissemination of the rating, ranking, tiering, or comparison. The written communication must include the specific reasons for the final decision.

(b) This section does not apply to the publication of a list of network physicians and providers if ratings or comparisons are not made and the list is not a product of nor reflects the tiering or classification of physicians or providers.

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

Sec. 1460.004. DUTIES OF PHYSICIANS. A physician may not require or request that a patient of the physician enter into an agreement under which the patient agrees not to:

- (1) rank or otherwise evaluate the physician;
- (2) participate in surveys regarding the physician; or
- (3) in any way comment on the patient's opinion of the physician.

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

Sec. 1460.005. RULES; STANDARDS. (a) The commissioner shall adopt rules as necessary to implement this chapter.

(b) The commissioner shall adopt rules as necessary to ensure that a health benefit plan issuer that uses a physician ranking system complies with the standards and guidelines described by Subsection (c).

(c) In adopting rules under this section, the commissioner shall consider the standards, guidelines, and measures prescribed by nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care, including the National Quality Forum and the AQA Alliance. If neither the National Quality Forum nor the AQA Alliance has

established standards or guidelines regarding an issue, the commissioner shall consider the standards, guidelines, and measures prescribed by the National Committee on Quality Assurance and other similar national organizations. If neither the National Quality Forum, nor the AQA Alliance, nor other national organizations have established standards or guidelines regarding an issue, the commissioner shall consider standards, guidelines, and measures based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship.

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

Sec. 1460.006. DUTIES OF HEALTH BENEFIT PLAN ISSUER. A health benefit plan issuer shall ensure that:

(1) physicians currently in clinical practice are actively involved in the development of the standards used under this chapter; and

(2) the measures and methodology used in the comparison programs described by Section 1460.003 are transparent and valid.

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.

Sec. 1460.007. SANCTIONS; DISCIPLINARY ACTIONS. (a) A health benefit plan issuer that violates this chapter or a rule adopted under this chapter is subject to sanctions and disciplinary actions under Chapters 82 and 84.

(b) A violation of this chapter by a physician constitutes grounds for disciplinary action by the Texas Medical Board, including imposition of an administrative penalty.

Added by Acts 2009, 81st Leg., R.S., Ch. 652 (H.B. 1888), Sec. 1, eff. September 1, 2009.